General

Guideline Title

Transition between inpatient hospital settings and community or care home settings for adults with social care needs.

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Transition between inpatient hospital settings and community or care home settings for adults with social care needs. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Dec 1. 29 p. (NICE guideline; no. 27).

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Institute for Health and Care Excellence (NICE) for the Department of Health (DH). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation), and are defined at the end of the "Major Recommendations" field.

Overarching Principles of Care and Support during Transition

Person-Centred Care

See everyone receiving care as an individual and an equal partner who can make choices about their own care. They should be treated with dignity and respect throughout their transition.

Identify and support people at risk of less favourable treatment or with less access to services for example, people with communication difficulties or who misuse drugs or alcohol. Support may include help to access advocacy.

Involve families and carers in discussions about the care being given or proposed if the person gives their consent. If there is doubt about the person's capacity to consent, the principles of the Mental Capacity Act must be followed.

Communication and Information Sharing

Ensure that the person, their carers and all health and social care practitioners involved in someone's move between hospital and home are in regular contact with each other. This is to ensure the transition is coordinated and all arrangements are in place. For more on medicines-related communication and medicines reconciliation during transitions, see the NGC summary of the NICE guideline Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes and NICE's guideline on managing medicines in care homes .

Give people information about their diagnoses and treatment and a complete list of their medicines when they transfer between hospital and home (including their care home). If appropriate, also give this to their family and carers.

Offer information in a range of formats, for example:

- Verbally and in written format (in plain English)
- In other formats that are easy for the person to understand such as braille, Easy Read or translated material (see the Accessible Information Standard)

Before Admission to Hospital

Health and social care practitioners should develop a care plan with adults who have identified social care needs and who are at risk of being admitted to hospital. Include contingency planning for all aspects of the person's life. If they are admitted to hospital, refer to this plan.

If a community-based multidisciplinary team is involved in a person's care that team should give the hospital-based multidisciplinary team a contact name. Also give the named contact to the person and their family or carer.

Health and social care practitioners and advocates should explain to the person what type of care they might receive. See NICE's guideline on patient experience in adult NHS services . Discussions might cover:

- Place of care
- Religion, culture and spirituality
- Daily routines (including the use of medicines and equipment)
- Managing risk
- How, when and where they receive information and advice
- The use of an advocate to support them when communicating their needs and preferences
- Advance care plans
- Contingency planning
- End-of-life care

Admission to Hospital

Communication and Information Sharing

Develop and use communication protocols and procedures to support admissions.

The admitting team should identify and address people's communication needs at the point of admission. For more information on communication needs see NICE's guideline on patient experience in adult NHS services .

Health and social care practitioners, including care home managers and out-of-hours general practitioners (GPs), responsible for transferring people into hospital should ensure that the admitting team is given all available relevant information. This may include:

- Advance care plans
- Behavioural issues (triggers to certain behaviours)
- Care plans
- Communication needs
- Communication passport
- Current medicines
- Hospital passport
- Housing status
- Named carers and next of kin

- Other profiles containing important information about the person's needs and wishes
- Preferred places of care

For an emergency admission, the accident and emergency department (A&E) should ensure that all available, relevant information is given to the admitting team when a person is transferred for an inpatient assessment or to an admissions ward.

The admitting team should provide the person and their family, carer or advocate with an opportunity to discuss their care. Also provide the following information:

- Reason for admission
- How long they might need to be in hospital
- Care options and treatment they can expect
- When they can expect to see the doctors
- The name of the person who will be their main contact (this is not necessarily the discharge coordinator)
- Possible options for getting home when they are discharged from hospital
- Care and treatment after discharge

The admitting team must identify whether there is a need for reasonable adjustments to be made to accommodate the person in hospital. This is in line with the Equalities Act 2010 . Examples include:

- Providing communication aids (this might include an interpreter)
- Ensuring there is enough space around the bed for wheelchair users to move from their bed to their chair
- Appropriate adjustments for carers

Establishing a Hospital-Based Multidisciplinary Team

As soon as the person is admitted to hospital, identify staff to form the hospital-based multidisciplinary team that will support them. The composition of the team should reflect the person's needs and circumstances. Members could include:

- Doctor
- Nurse
- Therapists
- Mental health practitioner
- Pharmacist
- Dietitian
- Specialists in the person's conditions
- Social worker
- Housing specialist
- Voluntary sector practitioners

The hospital-based multidisciplinary team should work with the community-based multidisciplinary team to provide coordinated support for older people, from hospital admission through to their discharge home.

Assessment and Care Planning

As soon as people with complex needs are admitted to hospital, intermediate care or step-up facilities, all relevant practitioners should start assessing their health and social care needs. They should also start discharge planning. If assessments have already been conducted in the community, refer to the person's existing care plan.

Start a comprehensive assessment of older people with complex needs at the point of admission and preferably in a specialist unit for older people.

During Hospital Stay

Record multidisciplinary assessments, prescribed and non-prescribed medicines and individual preferences in an electronic data system. Make it accessible to both the hospital- and community-based multidisciplinary teams, subject to information governance protocols.

At each shift handover and ward round, members of the hospital-based multidisciplinary team should review and update the person's progress towards hospital discharge.

Hospital-based practitioners should keep people regularly updated about any changes to their plans for transfer from hospital.

Provide care for older people with complex needs in a specialist, geriatrician-led unit or on a specialist geriatrician-led ward.

Treat people admitted to hospital after a stroke in a stroke unit and offer them early supported discharge. (See the NGC summary of NICE's guideline Stroke rehabilitation. Long-term rehabilitation after stroke.)

Encourage people to follow their usual daily routines as much as possible during their hospital stay.

Discharge from Hospital

Discharge Coordinator

Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital. Create either designated discharge coordinator posts or make members of the hospital- or community-based multidisciplinary team responsible. Select them according to the person's care and support needs. A named replacement should always cover their absence.

Ensure that the discharge coordinator is a central point of contact for health and social care practitioners, the person and their family during discharge planning. The discharge coordinator should be involved in all decisions about discharge planning.

Communication and Information Sharing

Health and social care organisations should agree clear discharge planning protocols.

Ensure that all health and social care practitioners receive regular briefings on the discharge planning protocols.

During discharge planning, the discharge coordinator should share assessments and updates on the person's health status, including medicines information, with both the hospital- and community-based multidisciplinary teams.

The hospital-based doctor responsible for the person's care should ensure that the discharge summary is made available to the person's GP within 24 hours of their discharge. Also ensure that a copy is given to the person on the day they are discharged.

Make a member of the hospital-based multidisciplinary team responsible for providing carers with information and support. This could include:

- Printed information
- Face-to-face meetings
- Phone calls
- Hands-on training, including practical support and advice

The discharge coordinator should provide people who need end-of-life care, their families and carers with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.

The discharge coordinator should consider providing people with complex needs, their families and carers, with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge.

Discharge Planning: Key Principles

Ensure continuity of care for people being transferred from hospital, particularly older people who may be confused or who have dementia. For more information on continuity of care see the recommendations in NICE's guideline on patient experience in adult NHS services .

Ensure that people do not have to make decisions about long-term residential or nursing care while they are in crisis.

Ensure that any pressure to make beds available does not result in unplanned and uncoordinated hospital discharges.

Discharge Planning

From admission, or earlier if possible, the hospital- and community-based multidisciplinary teams should work together to identify and address factors that could prevent a safe, timely transfer of care from hospital. For example:

- Homelessness
- Safeguarding issues
- Lack of a suitable placement in a care home
- The need for assessments for eligibility for health and social care funding

The discharge coordinator should work with the hospital- and community-based multidisciplinary teams and the person receiving care to develop and agree a discharge plan.

The discharge coordinator should ensure that the discharge plan takes account of the person's social and emotional wellbeing, as well as the practicalities of daily living. Include:

- Details about the person's condition
- Information about the person's medicines
- Contact information after discharge
- Arrangements for continuing social care support
- Arrangements for continuing health support
- Details of other useful community and voluntary services

The discharge coordinator should give the plan to the person and all those involved in their ongoing care and support, including families and carers (if the person agrees).

The discharge coordinator should arrange follow-up care. They should identify practitioners (from primary health, community health, social care, housing and the voluntary sector) and family members who will provide support when the person is discharged and record their details in the discharge plan.

The discharge coordinator should discuss the need for any specialist equipment and support with primary health, community health, social care and housing practitioners as soon as discharge planning starts. This includes housing adaptations. Ensure that any essential specialist equipment and support is in place at the point of discharge.

Once assessment for discharge is complete, the discharge coordinator should agree the plan for ongoing treatment and support with the community-based multidisciplinary team.

A relevant health or social care practitioner should discuss with the person how they can manage their condition after their discharge from hospital. Provide support and education, including coaching, if needed. Make this available for carers as well as for people using services.

Consider supportive self-management as part of a treatment package for people with depression or other mental health difficulties.

Discharge Planning for End-of-Life Care Needs

Ensure that people needing end-of-life care are offered both general and specialist palliative care services, according to their needs.

The named consultant responsible for a person's end-of-life care should consider referring them to a specialist palliative care team before they are transferred from hospital.

The discharge coordinator should ensure that people who have end-of-life care needs are assessed and support is in place so they can die in their preferred place.

Early Supported Discharge

Ensure that older people with identified social care needs are offered early supported discharge with a home care and rehabilitation package.

Consider early supported discharge with a home care and rehabilitation package provided by a community-based multidisciplinary team for adults with identified social care needs.

People at Risk of Hospital Readmission
The discharge coordinator should refer people at risk of hospital readmission to the relevant community-based health and social care practitioners before they are discharged.

If a person is homeless, the discharge coordinator should liaise with the local authority housing options team to ensure that they are offered advice and help.

Involving Carers

The hospital- and community-based multidisciplinary teams should recognise the value of carers and families as an important source of knowledge about the person's life and needs.

With the person's agreement, include the family's and carer's views and wishes in discharge planning.

If the discharge plan involves support from family or carers, the hospital-based multidisciplinary team should take account of their:

- Willingness and ability to provide support
- Circumstances, needs and aspirations
- Relationship with the person
- Need for respite

Support and Training for Carers

A member of the hospital-based multidisciplinary team should discuss the practical and emotional aspects of providing care with potential carers.

Ensure that training is available to help carers provide practical support. The relevant multidisciplinary team should offer family members and other carers of people who have had a stroke needs-led training in how to care for them. For example, this could include techniques to help someone carry out everyday tasks as independently as possible. Training might take place in hospital or it may be more useful at home after discharge.

The relevant multidisciplinary team should consider offering family members and other carers needs-led training in care for people with conditions other than stroke. Training might take place in hospital or it may be more useful at home after discharge.

The community-based multidisciplinary team should review the carer's training and support needs regularly (as a minimum at the person's 6-month and annual reviews). Take into account the fact that their needs may change over time.

After Transfer from Hospital

Community-based health and social care practitioners should maintain contact with the person after they are discharged. Make sure the person knows how to contact them when they need to.

An appropriately skilled practitioner should follow up people with palliative care needs within 24 hours of their transfer from hospital to agree plans for their future care.

A GP or community-based nurse should phone or visit people at risk of readmission 24 to 72 hours after their discharge.

Supporting Infrastructure

Ensure that a range of local community health, social care and voluntary sector services is available to support people when they are discharged from hospital. This might include:

- Reablement (to help people re-learn some of the skills for daily living that they may have lost)
- Other intermediate care services
- Practical support for carers
- Suitable temporary accommodation and support for homeless people

Have a multi-agency plan to address pressures on services, including bed shortages.

Ensure that all care providers, including GPs and out-of-hours providers, are kept up to date on the availability of local health, social care and voluntary services for supporting people throughout transitions.

Ensure that local protocols are in place so that out-of-hours providers have access to information about the person's preferences for end-of-life care.

Training and Development

Ensure that all relevant staff are trained in the hospital discharge process. Training should take place as early as possible in the course of their employment, with regular updates. It could include:

- Interdisciplinary working between the hospital- and community-based multidisciplinary teams, including working with people using services and their carers
- Discharge communications
- Awareness of the local community health, social care and voluntary sector services
- Available to support people during their move from hospital to the community
- How to get information about the person's social and home situation (including who is available to support the person)

- Learning how to assess the person's home environment (home visits)
- How to have sensitive discussions with people about end-of-life care
- Medication review in partnership with the person, including medicines optimisation and adherence
- Helping people to manage risks effectively so that they can still do things they want to do (risk enablement)
- How to arrange, conduct or contribute to assessments for health and social care eligibility.

Definitions

Recommendation Wording

The Guideline Committee makes recommendations based on an evaluation of the evidence, taking into account the quality of the evidence and cost effectiveness.

In general, recommendations that an action 'must' or 'must not' be taken are usually included only if there is a legal duty (for example, to comply with the Care Act or health and safety regulations), or if the consequences of not following it could be extremely serious or life-threatening.

Recommendations for actions that should (or should not) be taken use directive language such as 'agree', 'offer' 'assess', 'record' and 'ensure'.

Recommendations for which the quality of the evidence is poorer, or where there is a closer balance between benefits and risks, use 'consider'.

Clinical Algorithm(s)

A National Institute for Health and Care Excellence (NICE) pathway titled "Transition between inpatient hospital settings and community or care home settings for adults with social care needs overview" is provided on the NICE Web site .

Scope

Disease/Condition(s)

Any mental or physical illness or condition that requires transitions between general hospital settings and community or care home settings

Guideline Category

Management

Risk Assessment

Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Nursing

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Hospitals

Nurses

Patients

Pharmacists

Physical Therapists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Guideline Objective(s)

- To consider how person-centred care and support should be planned and delivered during admission to, and discharge from, hospital
- To address how services should work together and with the person, their family and carers, to ensure transitions are timely, appropriate and safe
- To improve people's experience of admission to, and discharge from, hospital by better coordination of health and social care services

Target Population

All adults, including older adults, with social care needs (defined as where an individual requires personal care and other practical assistance by reason of age, illness, disability, pregnancy, childbirth, dependence on drugs or any other similar circumstances) who are transitioning between general hospital settings and community or care home settings

Note: The guideline does not cover children and young people. It covers transitions between general hospital settings and community or care home settings. It does not include inpatient mental health settings.

Interventions and Practices Considered

1. Ensuring patient-centred care
2. Communication and information-sharing among patients, their carers and all health and social care practitioners
3. Developing a care plan before hospital admission
4. Developing and using communication protocols and procedures to support hospital admissions
5. Establishing a hospital-based multidisciplinary team
6. Assessment and care planning to ensure all health and social care needs are met within hospital
7. Recording multidisciplinary assessments, prescribed and non-prescribed medicines and individual preferences in an electronic data system during hospital stay
8. Regular review of patient's progress towards hospital discharge
9. Providing care in specialty units for older people (geriatrician-led unit) and people who have had strokes (stroke unit)
10. Coordinating and planning for discharge from hospital, including discharge planning, planning for end-of-life care needs, and early supported discharge
11. Identifying people at risk for hospital readmission
12. Involvement of and support and training for carers
13. Maintaining contact with the person after discharge
14. Ensuring a supporting infrastructure within the local community after discharge
15. Ensuring that all relevant staff are trained in the hospital discharge process

Major Outcomes Considered

- User and carer related outcomes
  - User and carer satisfaction
  - Quality and continuity of care
  - Quality of life measured using specific mental health quality of life tool
  - Choice and control
  - Involvement in decision-making
  - Suicide rates and mortality
  - Health status
  - Safety and safeguarding
  - Dignity and independence
- Service outcomes
  - Use of health and social care services
  - Delayed transfers of care
  - Rates of hospital readmissions within 30 days
- Cost-effectiveness of interventions

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Institute for Health and Care Excellence (NICE) for the Department of Health (DH). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

Search Strategies

The evidence reviews used to develop the guideline recommendations were underpinned by systematic literature searches. A systematic search strategy designed to identify empirical evidence to cover all of the review questions (based on the scope) was developed in the Medline database before being translated for use in the remaining databases (outlined below). Search strategies are listed at the end of Appendix A.

The search strategies were developed by conceptually breaking down the key themes identified from the review questions and the scope and combining relevant free text and controlled indexing terms in relation to:

1. Service user/patient transitions, transfer, admission or discharge
2. Relevant settings (inpatient hospital, community or care home settings)
3. Health and social care needs, health and social care workforce or health and social care intervention(s)

The selection of search terms for the systematic search strategies was kept broad (rather than individual searches for every question) in order to maximise the retrieval of evidence in a wide range of areas of interest to the Guideline Committee.

Searches were developed using database-specific subject headings and free text terms, aiming to balance the sensitivity and precision of the results, and the strategy was run across a number of health, social care, social science and economic databases. The searches incorporated database operational devices to take into consideration differing syntax, spelling variations and the use of plurals.

The searches were restricted to studies published from 2003 in order to incorporate the Community Care (Delayed Discharges) Act 2003 . Generic and specially developed search filters were used in order to retrieve specific quantitative and qualitative study designs including systematic reviews, randomised controlled trials, cohort studies, mixed method studies and personal narratives. The database searches were not restricted by country or by language. The sources searched are listed in the full version of the guideline below.

References submitted by Guideline Committee members and stakeholders were also considered.

Economic evidence was searched for as part of the wider search strategy and then economic databases National Health Service Economic Evaluation Database (NHS EED) and EconLit were also searched.

The bibliographic database searches were undertaken between March 2014 and April 2014. The Web sites of relevant organisations that produce empirical information were searched in May 2014. Forward citation searches of included studies was conducted in February 2015 using Google Scholar in order to identify additional potentially relevant studies. The database searches were re-run and re-executed in June 2015 and de-duplicated against the original search results in EndNote.

Number of Source Documents

See Appendix A (see the "Availability of Companion Documents" field) for detailed information on results of the literature searches and the number of included and excluded studies. See Figure A1 for a flowchart summarising excluded studies.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Quality Ratings for Individual Studies

Studies were rated for internal and external validity using ++/+/- (meaning good, moderate and low).

++ All or most of the checklist criteria have been fulfilled, and where they have not been fulfilled the conclusions are very unlikely to alter.

+ Some of the checklist criteria have been fulfilled, and where they have not been fulfilled, or are not adequately described, the conclusions are unlikely to alter.

- Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Institute for Health and Care Excellence (NICE) for the Department of Health (DH). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

When this guideline was started, the authors used the methods and processes described in the Social Care Guidance Manual (2013). From January 2015, the methods and processes in Developing NICE Guidelines: The Manual (2014) were used (see the "Availability of Companion Documents" field).

The included studies were critically appraised using tools in the manuals and the results tabulated (see Appendix B). Minor amendments were made to some of the checklists to reflect the range of evidence and types of study design considered in the evidence reviews. For more information on how this guideline was developed, including search strategies and review protocols, see Appendix A.

Rating the included studies was complex as the 'best available' evidence was often only of moderate quality. Studies were rated for internal and external validity using ++/+/- (see the "Rating Scheme for the Strength of the Evidence" field). Where there are 2 ratings (for example +/-), the first rating applies to internal validity (how convincing the findings of the study are in relation to its methodology and conduct), and the second rating

concerns external validity (whether it is likely that the findings can be applied to similar contexts elsewhere). The internal quality rating is given in the narrative summaries and evidence statements with both the internal and external rating reported in the evidence tables in Appendix B.

Economic studies have been rated according to their applicability using +/- and those rated applicable (+) have been rated according to the quality of methodology applied as economic analyses. Such studies are given (in the notation of -, + and ++) an 'economic evidence rating'. Methodological appraisal detailing the limitations of these studies is fully described in Appendix C1 in the full version of the guideline.

The critical appraisal of each study takes into account methodological factors such as:

- Whether the method used is suitable to the aims of the study
- Whether random allocation (if used) was carried out competently
- Sample size and method of recruitment
- Whether samples are representative of the population we are interested in
- Transparency of reporting and limitations that are acknowledged by the research team

Evidence rated as of only moderate or low quality may be included in evidence statements, and taken into account in recommendations, because the Guideline Committee independently and by consensus supported its conclusions and thought a recommendation was needed.

A further table reports the details (such as aims, samples) and findings. For full critical appraisal and findings tables, arranged alphabetically by author(s), see Appendix B.

Section 3.9.1 in the full version of the guideline provides a summary of the evidence source(s) for each recommendation. Section 3.9.2 in the full version of the guideline provides substantive detail on the evidence for each recommendation, presented in a series of linking evidence to recommendations (LETR tables).

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the National Institute for Health and Care Excellence (NICE) for the Department of Health (DH). See the "Availability of Companion Documents" field for the full version of this guidance and related appendices.

When this guideline was started, the authors used the methods and processes described in the Social Care Guidance Manual (2013). From January 2015, the methods and processes in Developing NICE Guidelines: The Manual (2014) were used (see the "Availability of Companion Documents" field).

Early in its discussions the Guideline Committee identified that a lack of clarity about responsibilities is a significant impediment to good transitions between hospital and home, and the importance therefore of being clear about this in developing the guideline. In drafting the recommendations the Committee therefore has specified the audience, and who should take action, in the body of the recommendation.

The review questions examining effectiveness of different interventions and approaches are used as the themes for the review areas reported (for example, transitions for people with mental health difficulties, transitions for people with end of life care needs). For every review area, the Committee also sought evidence on views and experiences. The result is that for each review area reported, evidence is presented from studies of effectiveness and from studies of views and experiences as they relate to that review area. Where relevant, evidence from economics studies is also reported.

The same views and experiences questions were applied for every review area, so as to supplement the more measurable data on effects. The views and experiences review questions which delivered material to supplement effectiveness studies are given in Section 3 in the full version of the guideline.

Due to the interrelatedness of some of the review areas, evidence was found to be overlapping. This was particularly so for the hospital admission process, hospital discharge and reducing readmissions review areas. As the review work progressed through the development phase, the Guideline Committee had an increasing body of evidence on which to develop recommendations. They were able to consider findings from one review area and apply them to the refinement of recommendations in other areas. Where evidence from one review area was used to inform recommendations

in another area, this is described in Section 3 in the full version of the guideline, including the 'Linking evidence to recommendations' tables.

Rating Scheme for the Strength of the Recommendations

Recommendation Wording

The Guideline Committee makes recommendations based on an evaluation of the evidence, taking into account the quality of the evidence and cost-effectiveness.

In general, recommendations that an action 'must' or 'must not' be taken are usually included only if there is a legal duty (for example, to comply with the Care Act or health and safety regulations), or if the consequences of not following it could be extremely serious or life-threatening.

Recommendations for actions that should (or should not) be taken use directive language such as 'agree', 'offer' 'assess', 'record' and 'ensure'.

Recommendations for which the quality of the evidence is poorer, or where there is a closer balance between benefits and risks, use 'consider'.

Cost Analysis

As part of the guideline development reviews of the economic literature are carried out. The review of economic evidence is presented in the full version of the guideline (see the "Availability of Companion Documents" field), which also demonstrates how it has been used to inform the review questions identified in the scope and the recommendations drawn from it by the Guideline Committee.

It was agreed that additional economic analysis would be carried out for review question 5:

'How do different approaches to care planning and assessment affect the process of admission to inpatient hospital settings from community or care home settings?'

The reasons were: first, recommendations in this area were expected to have important economic implications; second, there was relevant economic evidence; and, third, additional analysis was expected to be able to address the gaps in knowledge about cost-effectiveness.

For the other review areas covered by the scope, there was either sufficient economic evidence to answer the review question and additional economic analysis would not have added value or there was a lack of economic evidence and additional analysis was not considered feasible.

An exception to this was review question 11 which looked at support for families and unpaid carers during admission to or discharge from hospital. Two good quality studies were identified, which evaluated the costs and outcomes of a specific training intervention for carers of people with stroke at hospital discharge. Findings of a more recent larger trial did not suggest that this particular intervention was cost-effective. The authors concluded that a different type of intervention, provided in the form of comprehensive community support, might be more appropriate. It was also likely that practice had improved and that the comparison group was receiving appropriate support in a less formalised way. In principle, additional economic analysis could have been useful to achieve greater clarity about the likely cost effectiveness of this intervention. However, the Guideline Committee decided, based on the authors' conclusions and recommendation that this type of intervention was not sufficiently relevant to carry out further analysis.

Detail on the economic evidence that was identified for each review question and economic considerations is provided in the full version of the guideline. Refer to Appendix C3 for additional information on the economic analysis that was carried out for this guideline.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The guideline was validated through two consultations.

1. The first draft of the guideline (the full guideline and National Institute for Health and Care Excellence [NICE] guideline) was consulted with

Stakeholders and comments were considered by the Guideline Development Group (GDG).
2. The final consultation draft of the full guideline, the NICE guideline and the Information for the Public were submitted to stakeholders for final comments.

The final draft was submitted to the Guideline Review Panel for review prior to publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The type of evidence supporting each review question is detailed in the full version of the guideline (see the "Availability of Companion Documents" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- There is a small amount of evidence of moderate to good quality that improved communication between services and between services, patients and families would facilitate more successful discharge and improve the experiences of patients and families.
- The evidence demonstrated that if early supported discharge combined with rehabilitation is commissioned for older people this will result in better outcomes for individuals as well as being cost effective.
- Combined with the Guideline Committee's expertise, data demonstrated that if community-based health and social care practitioners follow people up via a visit or phone call and if people at risk of readmission are visited within 24 hours by a general practitioner (GP) or community nurse, then readmissions to hospital would be reduced.

Refer to the "Trade-off between benefits and harms" sections of the full version of the guideline for (see the "Availability of Companion Documents" field) for details about benefits of specific interventions.

Potential Harms

There is a small amount of evidence of good quality that out-of-hours general practitioner (GP) services can cause particular problems in the transition process for people with end of life care needs.

See the "Trade-off between clinical benefits and harms" sections in the full version of the guideline (see the "Availability of Companion Documents" field) for details about harms of specific interventions.

Qualifying Statements

Qualifying Statements

- This guideline has been developed in the context of a complex, rapidly evolving landscape of guidance and legislation, most notably the Care Act 2014.
- In line with the Care Act, the guideline covers health and health-related provision (including housing), and other care and support. It focusses on 'what works', how to fulfil those duties and how to deliver care and support. This guideline does not include transitions involving mental health settings, see National Institute for Health and Care Excellence's (NICE) guideline on transitions between inpatient mental health settings and community or care home settings.
- Refer to the "Context" section in the full version of the guideline (see the "Availability of Companion Documents" field) for additional details on how various legislation and policies affect the guidance.

- See the "Person-centred care" section in the full version of the guideline for information about individual needs and preferences and transition of care.

Implementation of the Guideline

Description of Implementation Strategy

Implementation: Getting Started

This section of the original guideline document highlights three areas of the transition between inpatient hospital settings and community or care home settings for adults with social care needs guideline that were identified as a focus for implementation. It explains the reasons why the change needs to happen. The section also gives information on resources and examples from practice to help with implementation. Refer to the original guideline document for additional information on these three areas of transition:

- Improving understanding of person-centred care
- Ensuring health and social care practitioners communicate effectively
- Changing how community- and hospital-based staff work together to ensure coordinated, person-centred support

Implementation Tools

Clinical Algorithm

Mobile Device Resources

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Transition between inpatient hospital settings and community or care home settings for adults with social care needs. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Dec 1. 29 p. (NICE guideline; no. 27).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

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Guideline Developer(s)

National Institute for Health and Care Excellence (NICE) - National Government Agency [Non-U.S.]

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Guideline Committee

Guideline Committee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

See Section 7 in the full version of the guideline (see the "Availability of Companion Documents" field) for declarations of interests made by the members of the Guideline Committee.

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the National Institute for Health and Care Excellence (NICE) Web site. Also available for download in ePub or eBook formats from the NICE Web site.

Availability of Companion Documents

The following are available:

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs. Full guideline. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Nov. 347 p. (NICE guideline; no. 27). Available from the National Institute for Health and Care Excellence (NICE) Web site.
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs. Appendices. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Dec. (NICE guideline; no. 27). Available from the NICE Web site.
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs. Baseline assessment tool. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Dec. (NICE guideline; no. 27). Available from the NICE Web site.
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs. Costing statement. London (UK): National Institute for Health and Care Excellence (NICE); 2015 Dec. 14 p. (NICE guideline; no. 27). Available from the NICE Web site.
- Developing NICE guidelines: the manual. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Oct. Available from the NICE Web site.
- The social care guidance manual. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Apr. Available from the NICE Web site.

Patient Resources

The following is available:

- Transition between inpatient hospital settings and community or care home settings for adults with social care needs. London (UK): National Institute for Health and Care Excellence; 2015 Dec. 6 p. (NICE guideline; no. 27). Available from the National Institute for Health and Care Excellence (NICE) Web site. Also available for download in eBook and ePub formats from the NICE Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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